ity was assessed in terms of convergent validity. **RESULTS:** 126 subjects returned the first questionnaire, of which 113 completed the second. Women represented 59.9% of the sample, and respondents' mean age was 56.8 +/– 18 years. 38.7% of subjects reported having chronic illness. The number of missing items from the descriptive EQ-5D (aggregated for both administrations) was 4, representing 0.33% of all responses. Five EQ-VAS responses were returned incomplete. 97 (85.8%) respondents reported no change in health in the fortnight between the first and second administration. The Spearman rank coefficients for these respondents were 0.828 for EQ-5D scores, and 0.815 for EQ-VAS, respectively (both $p < 0.000$). The results of the regression analysis for convergent validity suggested that, together, EQ-VAS score, self-reported health (5-point Likert scale; poor to excellent), presence of chronic illness, and receipt of treatment, explained 66.0% of the variation in EQ-5D scores. **CONCLUSION:** It is concluded that the Welsh version of the EQ-5D has good acceptability, validity and reliability in measuring health status in subjects across Wales.

PMC22

TRADING HEALTH VALUES IN CHILE AND THE US USING EQ-5D

Kind P[1], Zarate V[2], Olivares-Tirado P[3]
[1]Outcomes Research Group, Centre for Health Economics, University of York, York, UK, [2]Pontificia Universidad Catolica de Chile, Santiago, Chile, [3]Superintendencia de Salud, Santiago, Chile

OBJECTIVES: An understanding of the exchange rate in health values is a necessary requirement to the transfer of health outcomes data across national borders. As a preliminary to studying the valuation data for EQ-5D health states in US and Chile it is useful to establish the comparability in values for self-reported health in the two countries. **METHODS:** EQ-5D is a generic, single index measure of health-related quality of life. It was included as part of a national valuation study conducted in the US in 2003 that elicited responses from a subgroup of 1216 Hispanics aged 18 and over. Similar data using EQ-5D was collected in a national survey of health in Chile (n = 4258). All respondents were assigned to a unique EQ-5D health state defined by their level of reported problem on the 5 dimensions. The mean visual analogue scale (VAS) score for each of these health states was computed from respondents' rating of their own health status on a 0–100 scale ($EQ\text{-}5D_{VAS}$). Mean $EQ\text{-}5D_{VAS}$ scores for each available EQ-5D health state were compared across the 2 country samples. **RESULTS:** The value of self-assessed health status was generally higher in the US Hispanic subgroup than for the same EQ-5D health state in the Chilean survey with a mean absolute difference of 8.5. A linear regression model used to examine the relationship between values for the most prevalent self-assessed health in the two countries took the form $EQ\text{-}5D_{CHILE} = 0.773 * EQ\text{-}5D_{US\text{-}H} + 10.301$ **CONCLUSION:** Should this relationship in values for self-classified EQ-5D health states prove to be stable, then it could be used as a conversion factor to estimate values for EQ-5D in Chile from values obtained from Hispanic respondents in the US national survey. Data from surveys reporting values for actual health states appear to be useful in recalibrating scales of value for hypothetical health states.

PMC23

CONSISTENCY OF MINIMAL IMPORTANT DIFFERENCES FOR MAPPED UTILITY INSTRUMENTS IN FOUR MAJOR PATIENT GROUPS

Nichol MB, Epstein JD, Dow TD
University of Southern California, Los Angeles, CA, USA

OBJECTIVES: It is unknown whether minimal important differences (MID) identified on generic patient reported outcomes are consistent across disease states. This research compares mapped utility instrument MID values within four newly identified patient groups. **METHODS:** Retrospective analysis of a two-year longitudinal study in a Western US managed care population was conducted. Individuals receiving a prescription for a new disease state in either year were selected. Four major disease states, each with more than 100 patients reporting a minimal change in health over the past year on the SF-36 general health question were included. MID values were calculated for gains and losses in health on the Brazier, Lundberg, Nichol, and Shmueli mapped utility instruments. MID values between disease groups for each instrument were tested with ANOVA. Effect sizes were compared in accordance to Norman (2001) as a distribution-based method to determine the MID. **RESULTS:** Results are displayed for Brazier's SF-6D measure as all mapped utility instruments had similar results. 145, 240, 306, and 150 patients reported a minimal gain or loss in health over the year when they filled a new prescription for cardiac disease, COPD, depression and rheumatoid arthritis, respectively. The reported mean MID utility change for gains was 0.026, 0.022, 0.019, and 0.018 for each patient group, respectively ($P = 0.975$). The reported mean MID utility change for losses was –0.069, –0.045, –0.055, and –0.028 for each patient group, respectively ($P = 0.217$). The average effect sizes ranged from 0.133 and 0.194 for gains and from –0.241 and –0.627 for losses. Therefore, according to Cohen's classification system, the MID values in gains were not significant changes, while those in losses were considered small. **CONCLUSION:** This data demonstrates consistent, but small, MID values across various disease groups for each utility instrument. Researchers should confirm results in other populations.

PMC24

PSYCHOMETRIC EVALUATION OF INSTRUMENTS USED TO MEASURE PATIENT SATISFACTION WITH PHARMACIST SERVICES

Rollins B, Franic DM
University of Georgia, Athens, GA, USA

OBJECTIVES: Evaluate the practical and psychometric properties of the instruments used to measure patient satisfaction with pharmacist cognitive services, including medication therapy management and patient counseling. **METHODS:** After a comprehensive literature review, instruments were included based on: at least one peer-reviewed publication using the instrument, reference lists, instrument availability, and a focus on pharmacist cognitive services. The six measurement criteria used were: practical features (administration time), breadth (multidimensional construct), depth (floor and ceiling effects), internal consistency (coefficient alpha > 0.7) and test-retest reliability ($r > 0.7$), and validity. Measurement evaluation was based on McHorney and Tarlov's (1995) criteria for evaluation of outcome measurements and the recent Food and Drug Administration guide on patient reported outcome measures (2006). **RESULTS:** Of the 22 instruments identified, five were excluded because satisfaction was not measured as a multidimensional construct. Of the remaining 17 instruments, none met all six study criteria. A majority of the studies focused on patients' interaction with the pharmacist in a community pharmacy setting. Instruments were notable for the lack of reported psychometric data, especially test-retest reliability, which was reported in only one instrument. Only nine of 17 instruments reported internal consistency measures, but the nine reporting met study criteria (alpha > 0.7). The series of instruments developed by MacKeigan and Larson (1989, 1994,